

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of**  
**General Applicability**

**PROPOSED AMENDMENT**

**13 CSR 70-3.240 MO HealthNet Primary Care Health Homes.** The Division is revising sections (1), (3), and (4).

*PURPOSE: This amendment adds uncontrolled asthma in children and obesity as stand-alone chronic conditions that qualify MO HealthNet participants as Primary Care Health Home patients. The amendment also adds depression, anxiety, and substance use disorder as chronic conditions that, in combination with another qualifying chronic condition, qualify MO HealthNet participants as Primary Care Health Home patients. The amendment adds a performing provider requirement to Primary Care Health Homes with patients receiving services for a substance use disorder chronic condition. The amendment removes the no-longer applicable requirement for Health Home provider participation in learning collaboratives, and updates the Health Home certification requirements. The amendment revises Health Home team requirements to include a Physician Champion. Finally, the amendment updates the process for alerting Health Homes to potential enrollees, and simplifies how Primary Care Health Homes may share information with area hospitals on Health Home enrollees.*

**(1) Definitions.**

(A) EMR—Electronic Medical Records, also referred to as Electronic Health Records (EHR).

(B) Health Home—A primary care practice or site that provides comprehensive primary physical and behavioral health care to MHD patients with chronic physical and/or behavioral health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary care and to avoid preventable hospitalization or emergency department use for conditions treatable by the Health Home.

*[(C) Learning Collaborative—Group training sessions that primary care providers must attend if they are chosen to participate in the MO HealthNet Health Home program. The training will include meetings with mandatory attendance by certain officers and medical staff of the Health Home site and monthly conference calls.]*

[(D)] (C) Meaningful Use Stage One—The American Recovery and Reinvestment Act (ARRA) of 2009 created the Electronic Health Records (EHR) incentive payments program to provide Medicare or Medicaid incentive payments to eligible professionals in primary care practices. Meaningful use means that the eligible professionals or providers document that they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. Stage one of meaningful use means the eligible professionals meet twenty (20) out of twenty-five (25) meaningful use objectives as specified by the Centers for Medicare and Medicaid Services (CMS).

[(E)] (D) MHD—MO HealthNet Division, Department of Social Services.

[(F)] (E) NCQA—National Committee of Quality Assurance, *[the]* **an** entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.

[(G)] (F) Needy Individuals—Patients whose primary care services are either reimbursed by MHD or the Children’s Health Insurance Program (CHIP), or are provided as uncompensated care by the primary care practice, or are furnished at no cost or at reduced cost to patients without insurance.

[(H)] (G) Patient Panel—The list of patients for whom each provider at the practice site serves as the primary care provider.

[(I)] (H) CMS—Centers for Medicare and Medicaid Services.

**(I) The Joint Commission--an entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.**

### (3) Health Home Responsibilities After Selection.

(A) Health Home practice sites will *[be physician- or nurse practitioner-led]* **have a physician champion to provide physician leadership and encourage practice transformation to the Health Home model. Health Home practice sites** *[and]* shall form a health team comprised of, at a minimum, a primary care physician (i.e., family practice, internal medicine, or pediatrics) or nurse practitioner, *[a licensed nurse or medical assistant,]* a behavioral health consultant, **and** a nurse clinical care manager*[, and the practice administrator or office manager]*. The team will be supported as needed by the care coordinator, *[and]* Health Home Director, **and the practice administrator or office manager**. Other team members may include, for example, dietitians, nutritionists, pharmacists, or social workers.

(B) Practice sites selected to be MHD Health Homes shall participate in Health Home *[learning collaboratives. MHD will announce the dates and locations for learning collaborative meetings]* **webinars, care team forums, and other training opportunities.**

*[1. At a minimum, each Health Home practice site shall send to the learning collaborative meetings a team consisting of a senior clinician, another clinician, and a non-clinician member of the practice (site) such as the practice manager or practice administrator.*

*2. A Health Home will participate in monthly learning collaborative conference calls or webinars.*

*3.] A Health Home will participate in topical work groups as requested by MHD.*

*[4. A practice organization that has more than one (1) of its practice sites recognized by MHD as Health Homes, but not all of its sites selected for learning collaborative participation, shall designate a trainer to participate in a “train the trainer” program. The trainer shall attend the learning collaborative as a member of a practice’s core practice team and then train all of the organization’s other Health Home practice sites that were not selected for learning*

*collaborative participation. MHD or its designee shall identify content that the practice organization trainer will teach to the Health Home practice sites that do not participate in the learning collaborative.]*

(C) Health Homes shall convene practice team meetings at regular intervals to assist with the practice's transformation into a Health Home and to support continual Health Home evolution.

(D) A Health Home shall create and maintain a patient registry using EHR software, a stand-alone registry, or a third-party data repository and measures reporting system. The patient registry is the system used to obtain information critical to the management of the health of a primary care practice's patient population, including dates of services, types of services, and laboratory values needed to track chronic conditions. The Health Home's patient registry will be used for—

1. Patient tracking;
2. Patient risk stratification;
3. Analysis of patient population health status and individual patient needs; and
4. Reporting as specified by MHD.

(E) Primary care practice sites must transform how they operate in order to become Health Homes. Transformation involves mastery of thirteen (13) Health Home core competencies to be taught through the learning collaborative. The thirteen (13) core competencies are—

1. Patient/family/peer/advocate/caregiver-centeredness or a whole-patient orientation to care;
2. Multi-disciplinary team-based approach to care;
3. Personal patient/primary care clinician relationships;
4. Planned visits and follow-up care;
5. Population-based tracking and analysis with patient-specific reminders;
6. Care coordination across settings, including referral and transition management;
7. Integrated clinical care management services focused on high-risk patients including medication management, such as medication histories, medication care plans, and medication reconciliation;
8. Patient and family education;
9. Self-management support by members of the practice team;
10. Involvement of the patient in goal setting, action planning, problem solving, and follow-up;
11. Evidence-based care delivery, including stepped care protocols;
12. Integration of quality improvement strategies and techniques; and
13. Enhanced access.

(F) By the eighteenth month following the receipt of the first MHD Health Home payment, a practice site participating in the Health Home program shall demonstrate to MHD that the practice site has either—

1. Submitted to the National Committee of Quality Assurance (NCQA) an application for Health Home status and has obtained NCQA recognition of Health Home status **of at least** [*“Level 1 [Plus.]”*] **under the most recent NCQA standard** [*“Level 1 Plus” recognition is defined for these purposes as meeting 2011 NCQA Level 1 standards, plus recognition for achieving the following 2011 NCQA patient-centered medical home standard at the specified level of performance: Standard 3C at one hundred percent (100%), or at seventy-five percent (75%) with an acceptable plan of correction*]; or

2. *[Submitted]* **Applied** to *[NCQA an application for Health Home status and has obtained NCQA recognition of Health Home status at “Level 1 Plus,” defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus recognition for achieving the following NCQA 2008 PPC-PCMH standards at the specified levels of performance: Standard 3C at seventy-five percent (75%), Standard 3D at one hundred percent (100%), and Standard 4B at fifty percent (50%)]*  
**The Joint Commission for certification as a Primary Care Medical Home .**

(G) A Health Home shall submit to MHD or its designee the following information, as further specified by MHD or its designee, within the specified time frames:

1. Monthly narrative practice reports that describe the Health Home’s efforts and progress toward implementing Health Home practices;

2. Monthly clinical quality indicator reports utilizing clinical data obtained from the Health Home’s patient registry or third-party data repository;

*[3. Periodic submission of Medicaid Home Implementation Quotient (MHIQ) survey scores, as specified by MHD;]* and

*[4]* **3.** Other reports as specified by MHD.

(H) Practices selected to participate in the Health Home program must provide evidence of Health Home practice transformation on an ongoing basis using measures and standards established by MHD. Evidence of Health Home transformation includes:

1. Development of fundamental Health Home functionality at six (6) months and at twelve (12) months of entering the Health Home program, based on an assessment process to be applied by MHD or its designee;

2. Significant improvement on clinical indicators specified by and reported to MHD or its designee; and

3. Development of quality improvement plans to address gaps and opportunities for improvement identified during and after the Health Home application process.

(I) A Health Home must notify MHD within five (5) working days of the following changes:

1. *[If the employment or contract of a clinical care manager is terminated after the initiation of clinical care management payments]* **Changes in the employment or contracting of Health Home team members, or changes in the percentage of full time equivalent work time devoted to the Health Home by any Health Home team member; or**

2. If the Health Home experiences substantive changes in practice ownership or composition, including:

A. Acquisition by another practice;

B. Acquisition of another practice; or

C. Merger with another practice.

(J) Health Homes shall participate in evaluations determined necessary by CMS and/or MHD. Participation in evaluations may require responding to surveys and requests for interviews of Health Home practice staff and patients. Health Homes shall provide all requested information to an evaluator in a timely fashion.

(K) Within three (3) months of selection to be a Health Home, a practice site will develop *[agreements or memorandums of understanding to formalize traditional care planning with area hospitals, in which the hospitals agree to—*

1. *Notify the Health Home when Health Home patients are admitted to inpatient hospital departments;*

2. *Identify for the Health Home individuals seeking emergency department services who might benefit from connection with the Health Home;*

3. *Notify the Health Home when Health Home patients seek treatment in the hospitals' emergency departments; and*

4. *Refer patients to the Health Home for follow-up care]* **processes with area hospitals to share information on Health Home participants admitted to inpatient departments or seen in the emergency department.**

**(L) In order to provide Health Home services to a participant with substance use disorder and who is eligible for Health Home services in accordance with subparagraph (4)(A)2.A., a Primary Care Health Home practice must have at least one performing provider who qualifies and applies for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) to provide medication-assisted treatment.**

(4) Health Home Patient Requirements.

(A) To become a MO HealthNet Health Home patient, an individual—

1. Must be an MHD participant or a participant enrolled in an MHD managed care health plan; and

2. Must have at least—

A. Two (2) of the following chronic *[health]* conditions:

(I) Asthma;

(II) Diabetes;

(III) Cardiovascular disease;

(IV) A developmental disability; *[or]*

(V) Be overweight, as evidenced by having a *[n adult]* body mass index (BMI) *[over]* of **at least twenty-five (25) for adults, or being at or above the eighty-fifth (85<sup>th</sup>) percentile on the standard pediatric growth chart for children; *[or]***

(VI) Depression;

(VII) Anxiety; or

(VIII) Substance use disorder; or

B. One (1) chronic health condition and be at risk for a second chronic health condition as defined by MHD. In addition to being a chronic health condition, diabetes shall be a condition that places a patient at risk for a second chronic condition. Smoking or regular tobacco use shall be considered at-risk behavior leading to a second chronic health condition~~[/]; or~~

C. **One (1) of the following stand-alone chronic conditions:**

(I) Uncontrolled pediatric asthma as defined by MO HealthNet; or

(II) Obesity, as evidenced by having a BMI over thirty (30) for adults, or being **above the ninety-fifth (95<sup>th</sup>) percentile on the standard pediatric growth chart for children.**

(B) A **list of** participants eligible for Health Home services and identified by MHD as *[an]* existing users of **services at Health Home *[services]* practices** will be *[auto-assigned to a]* **provided monthly to each** Health Home based on qualifying chronic health conditions. *[A participant not enrolled in an MHD managed care health plan will be attributed to a Health Home using a standard patient algorithm adopted by MHD. A participant enrolled in an MHD managed care health plan will be attributed to a Health Home practice site that the participant has selected or to which the participant has been assigned by the health plan]* **Health Home organizations will determine enrollees from the lists provided by MHD as well as practice patients identified through the Health Homes' EMR systems.**

(C) After being *[assigned to]* **enrolled** in Health Homes, participants will be granted the option at any time to change their Health Homes if desired. *[A participant assigned to a Health Home*

will be notified by MHD of all available Health Home sites throughout the state. The notice will—

1. Describe the participant's choice in selecting a Health Home;
2. Provide a brief description of Health Home services, including the role of care managers and coordinators; and
3. Describe the process for the participant] **Participants will be given the opportunity to opt out of receiving services from their [assigned] Health Home providers.**

*[(D) Participants eligible for Health Home services who receive inpatient hospital or hospital emergency department services will be notified of eligible Health Homes and will be referred to Health Homes based on their choice of providers. Participants who are admitted to a hospital or who receive hospital emergency department services will be identified as eligible for Health Home services through the MHD comprehensive Medicaid electronic health record.*

*[(E) Health Home providers to which patients have been auto-assigned will be notified by MHD of patients' enrollment for Health Home services. The Health Homes will notify their patients' other treatment providers in order to explain Health Home goals and services, and to encourage their patients' other treatment providers to participate in care coordination efforts.]*

*AUTHORITY: section 208.201, RSMo Supp. [2011] **2013**.<sup>\*</sup> Original rule filed Dec. 15, 2011, effective July 30, 2012. Amended: Filed \_\_\_\_\_, 2016.*

*<sup>\*</sup>Original authority: 208.201, RSMo 1987, amended 2007.*

*PUBLIC ENTITY COST: This proposed amendment will cost state agencies or political subdivisions approximately \$1,844,321 in SFY 2017 and annually thereafter.*

*PRIVATE ENTITY COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*